

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-010774

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

53

Primary Registration District No.

3010

Registrar's No.

190

STATE FILE NUMBER

FILED APR 8 1963

1. PLACE OF DEATH a. COUNTY <u>Cape</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Length of stay in lb <u>1 day</u>	
c. FULL NAME OF <u>St. Francis Hosp.</u> HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>New Hamburg</u>	
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Jacob</u> Last <u>Westrich</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14 - 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
13a. FATHER'S NAME <u>John J. Westrich</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Glasser Coena M. LeGrand</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>No</u>)		16. SOCIAL SECURITY NO. <u>774</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Injury, Severe</u> DUE TO (b) <u>Skull Fracture</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		17. INFORMANT Address <u>MRS. Coena M. Westrich - New Hamburg</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fell down steps at his home.</u>	
20c. TIME OF INJURY Hour <u>10:00</u> p.m. Month, Day, Year <u>3-29-63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Residence</u>		20f. CITY, TOWN, OR LOCATION COUNTY <u>Scott</u> STATE <u>Missouri</u>	
21. I attended the deceased from <u>October 1958</u> to <u>March 30, 1963</u> and last saw him alive on <u>March 30, 1963</u> Death occurred at <u>5:35 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Edward D. Chaffee</u> M.D.		22b. ADDRESS <u>Cape Girardeau, Missouri</u>	
22c. DATE SIGNED <u>4-3-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>April 2, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Catholic Cem.</u>	
23d. LOCATION (City, town, or county) (State) <u>New Hamburg - Missouri</u>		24. FUNERAL DIRECTOR ADDRESS <u>Displingho PP Fun. Home - Chaffee Mo. 4-4-63</u>	
25. DATE RECD. BY LOCAL REG. <u>4-4-63</u>		26. REGISTRAR'S SIGNATURE <u>Drewn Kasten</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR TYPEWRITER RIBBON

VS 300
Rev. 4/59

1 1168

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APR 18 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jack T. Burnett

Licensed Embalmer No. 4472

P. O. Address Chaffee, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.